

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 6 1960

149

60-030502

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

4331

DEED

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO;</b> b. COUNTY <b>JACKSON</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>50 yrs.</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>306 GLADSTONE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>306 GLADSTONE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EILEEN</b> Middle <b>MARY</b> Last <b>CUTTER</b>				4. DATE OF DEATH Month <b>AUG.</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 20 - 67</b>		AGE (last birthday) <b>62</b>		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (City and state or country) <b>PORTSMOUTH, OHIO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>WILLIAM GRAHAM</b>		13b. MOTHER'S MAIDEN NAME <b>MAUDE McDONALD</b>		14. NAME OF HUSBAND OR WIFE <b>R.L. CUTTER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>*****</b>		17. INFORMANT <b>R. L. CUTTER</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia due to purulent cellulitis</b> DUE TO (b) <b>Left iliac fossa</b> DUE TO (c) <b>Rheumatoid Arthritis, severe</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>20 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>diabetes mellitus</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <b>-</b> a.m. <b>-</b> p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>Nov-5-50</b> to <b>Aug-21-60</b> and last saw her alive on <b>Aug-20-60</b> Death occurred at <b>8:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Carl H. Brust</b>		(Degree or title) <b>M.D.</b>		22b. ADDRESS <b>106 W 14th St Kansas City Mo</b>		22c. DATE SIGNED <b>8/23/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>AUG. 24, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BROOKINGS CEM.</b>		23d. LOCATION (City, town, or county) <b>RAYTOWN, MISSOURI</b>	
24. FUNERAL DIRECTOR <b>C. H. BLACKMAN &amp; SON</b>		ADDRESS <b>I.C. K.C. MO. P-23-60</b>		25. DATE RECD. BY LOCAL REG. <b>11-5</b>		26. REGISTRAR'S SIGNATURE <b>Dwyer</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Carl H. Brust

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W. C. Davis

Licensed Embalmer No. 482

P. O. Address N. C. 7m

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.